

## Possible human rabies — patient information form

A copy of this form must accompany diagnostic specimens. Send completed form to:

Epidemiology Section VRZB

CDC MS-13

1600 Clifton Road, NE

Atlanta, Georgia 30333

**FAX:** Attn: Rabies EIS Officer (404) 639-2778

Please fill out the following form as completely as possible. The first three sections (Patient Information, Symptoms, and Laboratory Findings) are required.

### Patient information:

Date (mm/dd/yy)	
Physician's name	
Physician's phone #	
Patient's name	
Patient's gender	Female_____ Male
Patient's date of birth	
Patient's occupation	

### Symptoms:

Which of the following symptoms have been present? Mark all that apply.

	Yes	No	Unk		Yes	No	Unk
Fever				Aerophobia			
Malaise				Hydrophobia			
Headache				Localized weakness			
Nausea/vomiting				Localized pain/paraesthesia			
Anxiety				Confusion or delirium			
Muscle spasm				Agitation/combativeness			
Dysphagia				Autonomic instability			
Anorexia				Hyperactivity			
Ataxia				Hallucinations			
Priapism				Insomnia			
Seizures				Hypersalivation			

**Laboratory findings:**

<b>Peripheral WBC (with diff)</b>	<b>On admission:</b> WBC	X 10 <sup>3</sup> µl
	neutrophils	%
	lymphocytes	%
	monocytes	%
	bands	%
	<b>Highest:</b> WBC	X 10 <sup>3</sup> µl
	neutrophils	%
	lymphocytes	%
	monocytes	%
	bands	%
<b>Chemistry</b>	glucose, serum	mg/dl
	total protein, serum	g/dl
	CPK, serum -total	U/dl
	Isoenzymes -MM	%
	MB	%
	BB	%
<b>CSF findings</b>	RBC	/ µl
	WBC	/ µl
	neutrophils	%
	lymphocytes	%
	monocytes	%
	bands	%
	glucose	mg/dl
	protein	mg/dl

**CSF culture results:****Additional abnormal laboratory findings:**

**Additional pertinent clinical information:****Additional information:**

Location of residence at time of onset	___1. urban ___2. suburban ___3. rural
	City: State:
Has the patient traveled to any foreign country in the past 6 months?	country 1: number of weeks:
	country 2: number of weeks:
Any suspicious animal exposures?	Date of exposure (mm/dd/yy):
Species involved in <b>most recent exposure</b> (circle):	dog cat raccoon skunk fox bat other
Type of exposure (circle):	bite nonbite(scratch) nonbite(contact only) no known exposure unknown
City and state of most recent exposure:	
Species involved in <b>previous exposure</b> (circle):	dog cat raccoon skunk fox bat other
Date of exposure (mm/dd/yy):	
Type of exposure (circle):	bite nonbite(scratch) nonbite(contact only) no known exposure unknown
City and state of previous exposure:	
First symptoms:	
Date of onset of illness (mm/dd/yy):	
Outpatient visit date (mm/dd/yy):	
Outpatient diagnosis:	
Hospitalized?	___yes ___no Date:
Admitting diagnosis	
Is/was patient in a coma?	___yes ___no Date:
Has patient expired?	___yes ___no Date of death:
Current differential diagnosis:	